SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

HOME AND COMMUNITY BASED WAIVER Policy Manual	Section: ELIGIBILITY FOR SERVICES
	Subject: Termination of Services

References: ARM: 37.40.1408

TERMINATION OF SERVICES

The Department will provide written notice to applicants and members at least ten working days before the date of an adverse action.

➢Case Management Team (CMT) issues a Letter of Notification, (SLTC-144), (refer to HCBS 899-18) to provide notification of adverse action for all reasons except terminations and denials based on level of care for which the Mountain Pacific Quality Health completes the SLTC-61 (refer to HCBS 599-1). The Office of Public Assistance (OPA) will issue adverse actions resulting from Medicaid financial ineligibility. However, members receiving Medically Needy Medicaid may not receive notice for up to 90 days, so a SLTC-144 is required. The SLTC-144 and SLTC-61 informs the member how to request a fair hearing.

CIRCUMSTANCES THAT REQUIRE A SLTC-144 WITH ADVANCED WRITTEN NOTICE

The CMT must send advance written notice at least ten working days prior to the date of adverse action when Home and Community Based Services (HCBS) are denied or terminated for any of the following reasons:

1. Termination due to lack of HCBS program funds. The Department will provide at least 30 days of notice before any termination of services due to insufficient program funds;

2. The plan of care costs exceed the maximum limit; or

3. Termination of HCBS for other reasons. In this instance, the CMT completes the DPHHS-SLTC-144 with concurrence from the Regional Program Officer (RPO) and indicates reasons for termination.

EXCEPTIONS FROM ADVANCE NOTICE

Terminations for the reasons listed below do not require advance notice, but still require the SLTC-144:

1. The member is admitted to a nursing facility, hospital or transitional care unit (TCU);

2. The member requests in writing that services be terminated or refuses to sign the plan of care; or

3. Discharge of a medically needy member from HCBS because of failure to pay incurment.

NOTE: DO NOT COMPLETE A SLTC-144 WHEN THE MEMBER DIES. The effective date of HCBS discharge is the date of death.

ADMISSION TO A HOSPITAL, NURSING FACILITY, TRANSITIONAL CARE UNIT (TCU)

If a member is admitted to a hospital, nursing facility, or transitional care unit (TCU) no payment for HCBS can be made during the member's stay in this setting. However, it is permissible for the CMT to bill for case management and other services provided on the day of facility admission and the day of facility discharge if the member returns to HCBS. If the member remains in the facility for more than 30 days, the CMT must discharge the member from HCBS. The discharge date should be the date of admission to the facility. (Refer to HCBS 410 Retainer Payments for exceptions to this policy).

In the event of discharge, a CMT may elect to hold the slot open and re-enroll the member at a later date. The Department considers the decision to leave the slot vacant to be an internal decision on the part of the CMT. No Medicaid payment for HCBS is allowed for those days. (Refer to re-enrollment process in this section on page 3.)

SERVICES PRIOR TO DISCHARGE FROM HOSPITAL/ NURSING HOME

Services (e.g., home modification, community transition service, homemaker) that need to be provided to assist the member to return to a community setting can be arranged and completed prior to the

member's discharge from the hospital or nursing facility, but must not be billed until the member returns home (date of HCBS admission).

If the member is unable to return to his residence (e.g., death or alternate placement), payment for services provided prior to hospital/nursing facility discharge can be reimbursed by Medicaid. However, the CMT must have completed a Plan of Care (form DPHHS-SLTC 135) or Plan of Care Short form (form DPHHS-SLTC-135-B) prior to the commencement of such services for reimbursement to be approved. Contact RPO for approval and process.

TEMPORARY ABSENCES

The member can be temporarily absent from home for up to 30 days for vacations, visits, and to receive outpatient medical care and continue to receive HCBS. In order for CMT to bill during a temporary absence, there must be a plan for the member to return home.

Refer to HCBS 410 Retainer Payments regarding payment for Personal Assistance Services (PAS) and Residential Habilitation.

EXTENDED ABSENCE

Occasionally a member may require an absence of more than 30 days but still plans to return to HCBS. The CMT must discharge the member, however, they may elect to hold the slot open and re-enroll the member upon return. The department considers the decision to leave the slot vacant to be an internal decision on the part of the CMT. No Medicaid payment for HCBS is allowed in these instances.

DISCHARGE PROCEDURE

The CMT must provide discharge planning for members who will be terminated from services and complete the Discharge Sheet, (SLTC-137) refer to HCBS 899-13. A discharge notification must be sent to all appropriate individuals involved in the member's plan including the health care professional, and service providers. The CMT must send a MA-55 form to the Office of Public Assistance (OPA) Eligibility Staff. Refer to HCBS 899-6.

RE-ENROLLMENT

If a member has been discharged from HCBS for a hospital, nursing facility or TCU stay exceeding 30 days or other extended absence from home and the CMT is holding the member's slot open, the CMT does not need to complete a new service plan unless a change in the member's condition warrants it. An Intake Sheet (SLTC 136) must be faxed to MPQH, and a MA-55 form sent to the Office of Public Assistance (OPA). A Request for Level of Care form (SLTC-85) must be submitted to MPQH in all cases if there is a one day break in long

term care services (HCBS or nursing home). Therefore, if a member moves from HCBS to nursing home and directly back to HCBS a new LOC is not required. In all other cases a new LOC is required prior to re-enrollment in HCBS.

CIRCUMSTANCES REQUIRING A SLTC-55

1. Entrance into waiver services
2. Discharge from waiver services

If a member is absent from services for less than 30 days, due to an admission to a hospital, nursing facility or TCU, the CMT does not have to discharge or submit a MA-55. The CMT needs to send written communication to OPA indicating the member has been admitted to a nursing facility, hospital, or TCU, and that the waiver span should be kept open because the institutional placement is temporary.